Best Practices for Care Transitions:
Engaging Emergency Departments and Urgent Care Centers

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Who is missing?
Outline for today

• Role of QIOs
• The opportunity
• Safe Transitions Best Practices
• Other approaches
• Moving forward
What is a QIO?

- CMS-contracted network across the country
- Active in all healthcare settings
- Focused on
  - Patient safety
  - Healthcare quality
  - Beneficiary rights
Rhode Island’s Safe Transitions Project

• Medicare-funded pilot, 2008-2011
  – Competitively awarded
  – Only 14 nationwide
  – Cross-setting

• Medicare-funded expansion, 2011-2014
  – All states
  – Building on prior work
Our vision

A healthcare system where patients and their caregivers understand their conditions and medications, know who to contact with questions (and when), and are supported by healthcare professionals who have access to the right information, at the right time.
Rhode Island’s Safe Transitions Project

- Medicare-funded pilot, 2008-2011
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- Medicare-funded expansion, 2011-2014
  - All states
  - Building on prior work
Select interventions

• Five community coalitions
• On-site technical support for providers
• Statewide learning and action network
• Spread of the Safe Transitions Best Practices
Select interventions

- Five community coalitions
- On-site technical support for providers
- Statewide learning and action network
- Spread of the Safe Transitions Best Practices
Why Emergency Departments?

• 130 million ED visits a year
• High acuity of patients
• PCPs have to immediately assume care
  – Waste time requesting records
  – Incur cost, patient discomfort with repeat testing
• Default: refer patients back to the ED

NHAMCS, 2010.
Patient flow to and from the ED

- Self-Referral, Walk-in
- Self-Referral, Ambulance
- Physician Office, Home Health, Nursing Home
- Urgent Care Center
- Emergency Department
- Hospital
What’s the current status?

• 23% of PCPs always notified
• Variability in quality and consistency of information transfer
• Limited research
• No national guidelines

Schoen, 2012.
Can patients fill the gap?

• Limitations in discharge instructions
  – Given in as little as two minutes
  – No assessment of understanding
  – Missing key details
• Inconsistent patient comprehension or recall
• Variation in patient adherence to follow-up appointments or prescribed meds

Rhodes, 2004; Schoen, 2012; Vashi, 2011
What’s the solution?

- Identify best practices for care transitions
- Provide information needed to assume responsibility for patient care
- Detail expectations for communication
- Incorporate elements of patient activation
- Focus on actions within control of the setting
What is a Best Practice?

<table>
<thead>
<tr>
<th>Timely, accurate information transfer:</th>
<th>ED</th>
<th>UCC</th>
<th>HHA</th>
<th>PCP</th>
<th>NH</th>
<th>Hosp</th>
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<td>- To providers</td>
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</table>
How did we do it?

1. Reviewed evidence base
2. Gathered state-wide preferences
3. Developed preliminary draft
4. Convened community meetings
5. Vetted with advisory board
Safe Transitions Best Practices: ED

- Document patients’ primary care provider
- Document patients’ home care provider
- Send summary clinical information to PCP/home care at discharge
- Send summary clinical information to receiving facility (e.g., NH)
- Perform modified medication reconciliation
- Provide effective education to patients and their families
- Provide written discharge instructions
Asking for: reciprocal change
What are (some of) the barriers?

- Time and workflow concerns
- Little incentive to participate
- If viewed as “non-essential,” not prioritized
- Other competing new tasks
- Misaligned ED metrics
What can help remove barriers?

• Health system priorities
• Shared risk payment models
• Contracting requirements
• Focus on patient satisfaction as quality measure
Closing the loop: best practices for cross-setting communication at ED discharge

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ABSTRACT

Purpose: This study aimed to develop emergency department best practice guidelines for improved communication during patient care transitions.

Basic Procedures: To our knowledge, there are no specific guidelines for communication at the point of transition from the emergency department to the community. In Rhode Island, we used a multistage collaborative quality improvement process to define best practices for emergency department care transitions. We reviewed the medical literature, consensus statements, and materials from national campaigns; gathered preferences from emergency medicine and primary care clinicians; and created guidelines that we vetted with emergency medicine clinicians and other key stakeholders.

Main Findings: Because we did not find any guidelines that globally addressed care transitions from the emergency department, we drew from studies on patient discharge instructions and extrapolated from the evidence base available for other, related settings. Our key outcome is a set of care transition best practices for emergency departments, which can be implemented to establish measurable, communitywide expectations for cross-setting clinician-to-clinician communication. They include obtaining information about patients’ outpatient clinicians, sending summary clinical information to downstream clinicians, performing modified...
Why Urgent Care Centers?

• Patients increasingly using them
• Utilization can fragment care
• Many do not send information to PCPs at all
• Variation in type of information sent
• RI physicians identified this as a need

Weinick, 2007; Patwardhan, 2012
Communication is not adequate
Patient flow to and from an UCC

No Regular Physician

Physician Office (Referred or Self Referred)

Urgent Care Center

Emergency Department
Safe Transitions Best Practices: UCC

- Document patients’ primary care provider
- Document patients’ home care provider
- Send summary clinical information to PCP/home care at discharge
- Send summary clinical information to the ED upon patient referral
- Perform modified medication reconciliation
- Provide effective education to patients and their families
- Provide written discharge instructions

A product of Healthcentric Advisors
What are (some of) the barriers?

• Difficult to identify who they are
  – Many definitions and names
  – No central body
  – Varying regulatory requirements

• Many physician types

• Little incentive to participate

• Often not part of larger health systems

• Minimal scholarship, no specific journals
What can help remove barriers?

- Partnership with PCP offices for 24/7 access
- Strengthened reputation among ED/PCP → generates referrals
  - Contracting requirements by payers
- In RI, could be condition of participation
What are others working on?

Implementation of a Web-Based System to Improve the Transitional Care of Older Adults

Zeke Zamora, MD; Brenda McCall, BSN, RN; Laura Patel, MD; Kevin Biese, MD; Michael LaMantia, MD; Tim Platts-Mills, MD; Nelson Naus, BS; Hans P. Jerkewitz, BS; Charles B. Cairns, MD; Jan Busby-Whitehead, MD; John S. Kizer, MD

We constructed a bidirectional Web-based system to transmit critical patient information in real time between referring nursing homes and a university hospital emergency department (ED) to facilitate the care of patients referred to our ED. Our model was inexpensive, improved measures of information transfer, and increased provider satisfaction. Key words: electronic medical records, quality improvement, transitional care

In 2004, The Centers for Disease Control and Prevention estimated that 8% of the US nursing home (NH) residents had an emer-
What are others working on?

Strategies To Address Frequent Emergency Department Use

In many hospital emergency departments (EDs), a small percentage of patients account for a disproportionate share of visits and resources. Sometimes referred to as ED “super users,” these individuals often lack a regular source of care and typically present to the ED with non-urgent conditions, often with a variety of underlying medical, behavioral, and psychosocial needs that cannot be addressed in the ED.

The featured Innovations describe three programs that implemented various strategies to provide, manage, and coordinate care and social services for individuals who are frequent ED visitors.
What are lessons learned?

• Convene your partners early
  – Expect a period of storming and norming
  – Allow time to build foundation for behavior change

• Facilitate discussion
  – Let participants’ voices prioritize next steps

• Use data to drive decision making

• Remember that it’s all about relationships
How to sustain and spread?

• Move local success to system success
  – Stakeholder consensus to align incentives
  – Change in expectations about communication

• Develop shared ownership

• Publish and present your work
As you look forward

- Employ QIO’s role as a neutral convener
- Bring all healthcare settings to the table
- Invite the payers
- Align with other initiatives in the environment
- Harness emerging payment models
Readmissions Reduction Program
"The greatest opportunities for improving care transitions center around improving communication, building cross-setting relationships and redesigning our workflow."

Eric Coleman, MD, MPH
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